Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
FIRST LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-3647-01

MFDR Date Received
April 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account. Per the new fee schedule this account qualifies for an Outlier payment..."

Amount in Dispute: $2,417.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With the initial payment issued and subsequent appeals, CPT 62311 billed by the provider as the procedure performed was denied as not documented in the operative report as performed... South Texas Health Systems at Plano did not correct the coding with either of the appeals sent… It is also noted, Dr. Keys, who is documented as performing the facet injections for this date of service, billed and was paid for the correct codes of CPT 64475 and 64476."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2009	Outpatient Hospital Services	$2,417.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X668 – VENIPUNCTURE CHARGES ARE INCLUDED IN THE GLOBAL LAB FEES. (X668)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - X129 – PROCEDURE NOT DOCUMENTED IN OPERATIVE REPORT. (X129)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Does the documentation support procedure code 62311?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT," and Z547 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTACT AND OUR ACCESS AGREEMENT WITH THEM." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier denied procedure code 62311 with reason code X129 – "PROCEDURE NOT DOCUMENTED IN OPERATIVE REPORT." The respondent's position statement asserts "With the initial payment issued and subsequent appeals, CPT 62311 billed by the provider as the procedure performed was denied as not documented in the operative report as performed... South Texas Health Systems at Plano did not correct the coding with either of the appeals sent… It is also noted, Dr. Keys, who is documented as performing the facet injections for this date of service, billed and was paid for the correct codes of CPT 64475 and 64476." Per 28 Texas Administrative Code §133.20(c), "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Procedure code 62311 is defined as "Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)." Review of the *Operative Report* finds that the services performed were bilateral injection of the facets at L4-L5 and L5-S1and "into the gutter over the superolateral border of the facet where the medial branch recurs." Review of the submitted information finds no documentation to support injection of the subarachnoid cavity of the spinal cord or the epidural space of the spinal canal. The submitted documentation does not support the service as billed. The Division concludes that the requestor has not met the requirements of §133.20(c). The insurance carrier's denial reason is supported. Reimbursement for procedure code 62311 is not recommended.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific

amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.44. 125% of this amount is $19.30. The recommended payment is $19.30.
   - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.
   - Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.28. 125% of this amount is $4.10. The recommended payment is $4.10.
   - Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $24.28. The non-labor related portion is 40% of the APC rate or $17.88. The sum of the labor and non-labor related amounts is $42.16. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $42.16. This amount multiplied by 200% yields a MAR of $84.32.
   - Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $26.09. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.65. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $14.17. The non-labor related portion is 40% of the APC rate or $10.44. The sum of the labor and non-labor related amounts is $24.61. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $24.61. This amount multiplied by 200% yields a MAR of $49.22.

5. The total recommended payment for the services in dispute is $174.88. This amount less the amount previously paid by the insurance carrier of $181.44 leaves an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	September 7, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.